EXHIBIT A

* Final Report *

Indication for Surgery
This right-handed married 54-year-old Cuban male waste hauling company owner crushed his right fifth finger in his truck rear door this morning. Patient has no allergies and takes no medication.

Preoperative Diagnosis
1. Open fracture distal phalanx right third finger, comminuted.
2. Extensor tenolysis right third finger distal phalanx insertion.
3. Subungual hematoma and volar pad hematoma, right third finger.
4. 4.0 cm mid- dorsal bursting laceration, eponychium to proximal middle phalanx.
5. Volar pad lacerations 2.5 cm and 1.5 cm.

Postoperative Diagnosis
1. Open fracture distal phalanx right third finger, comminuted.
2. Extensor tenolysis right third finger distal phalanx insertion.
3. Subungual hematoma and volar pad hematoma right third finger.
4. 4.0 cm mid dorsal bursting laceration, eponychium to proximal middle phalanx.
5. Volar pad lacerations 2.5 cm and 1.5 cm.

Operation
1. Digital block right third finger
2. Exsanguinating tourniquet.
3. Wound exploration irrigation preparation and drainage of subungual and volar pad hematomas.
4. Repair Volar bursting lacerations 0.5 cm and 1.5 cm.
5. Joint pinning DIP joint in extension with 2- 18-gauge pins.
6. Extensor tenodesis.
7. Fine plastic wound closure volar dorsal wound, 4.0 cm.
8. Tourniquet release.
9. Occlusive dressings and extreme elevation.

Surgeon(s)
Robert S. Fischer MD

Anesthesia
9.5 cc 1% Xylocaine plain digital block

Estimated Blood Loss
20 cc

Findings
This otherwise healthy appearing 54-year-old Cuban male presented with a complex crush injury of the dominant right third finger with a 4 cm longitudinal dorsal bursting wound from the proximal middle phalanx to the eponychium. The underlying dorsal extensor apparatus is 80% severed from its insertion. There is a subungual hematoma. There are 2 lacerations on the volar aspect of the fingertip pad 2.5 cm and 1.5 cm there is a volar pad hematoma. The wound was bleeding vigorously

Specimen(s)
None

Complications
None

Technique

Advance Directive
Advance Directive: No (02/19/19 09:51:00 EST)

Code Status
No qualifying data available.

The right hand was prepped with Betadine and saline and peroxide and draped appropriately.

A digital block was accomplished with 9.5 cc of 1% Xylocaine plain.

A latex glove finger was placed on the digit, fenestrated distally and rolled distal to proximal as an exsanguinating tourniquet.

The volar wound was explored and irrigated with peroxide and Betadine no foreign bodies were noted.
The 2 volar pad wounds were repaired with interrupted sutures of 5-0 Surgipro blue polypropylene.

The right hand was then pronated and the massive dorsal wound was addressed. Hemostasis was obtained with electrocautery and a second exsanguinating tourniquet was required because of continued bleeding.

The nail plate was fenestrated with the cautery tip to release the subungual hematoma and the volar pad was fenestrated as well with the cautery tip to allow egress of a bloody collection within the finger pad.

The finger was pinned in extension at the DIP joint with 2-18-gauge pins crisscrossed at approximately the level of the joint.

And extensor tenodesis was done using 3-0 blue Surgipro monofilament, using a Kessler technique and reinforced with a simple sutures of the same.
The wound was irrigated with peroxide and Betadine and no foreign bodies were noted.

The wound was then closed with several key sutures of 4-0 Surgipro blue monofilament as locked vertical mattress sutures and interrupted simple sutures of the same and 5-0 blue Surgipro.

The tourniquet at the base of the digit was released and circulation appeared quite adequate.

The finger was dressed with Xeroform gauze, fluff Kerlix, and circumferential wrappings of 3 inch and 4 inch conform stretch dressing applied as an occlusive but non-constrictive bandage and incorporating the index finger.

Postoperative Care Instructions

Patient will be given prescriptions for Keflex and analgesics. He was instructed to keep the hand elevated no lower than the right ear for the next 4 days after which it may go into a sling which was provided.

Patient will be seen in the office in 1 week for wound care and follow-up.

He is to keep the dressings clean and dry and protected in the shower with a plastic bag while holding it vertically with an elastic about the forearm. His to sleep with it up on 2 pillows in bed.

Signature Line
Electronically Signed on 02/19/19 01:42 PM

Operative Report
* Final Report *

T[redacted] OTTO [redacted] 5051982

Fischer, MD, Robert S

EXHIBIT B

Robert S Fischer, MD
19-21 Fair Lawn Ave
Fair Lawn, NJ 07410
Tax ID# 221998045
NPI# 1174695001

ASSIGNMENT OF BENEFITS
&
LTD. POWER OF ATTORNEY

I irrevocably assign to you, my medical provider, all of my rights and benefits under my insurance contract for payment for services rendered to me. I authorize you to file insurance claims on my behalf for services rendered to me and this specifically includes filing arbitration/litigation in your name on my behalf against the PIP carrier/health care carrier. I irrevocably authorize you to retain an attorney of your choice on my behalf for collection of your bills. I direct that all reimbursable medical payments go directly to you, my medical provider. I authorize and consent to your acting on my behalf in this regard and in regard to my general health insurance coverage pursuant to the "benefit denial appeals process" as set forth in the NJ Administrative Code.

In the event the insurance carrier responsible for making medical payments in this matter does not accept my assignment, or my assignment is challenged or deemed invalid, I execute this **limited/special power of attorney** and appoint and authorize your collection attorney as my agent and attorney to collect payment for your medical services directly against the carrier in this case, in my name, including filing an arbitration demand or lawsuit. I specifically authorize that attorney to file directly against that carrier in my name or in your name as a medical provider rendering services to me and designate your collection attorney as my attorney in fact. I further grant limited power of attorney to you as my medical provider to receive and collect directly from the insurance carrier money due you for services rendered to me in this matter, and hereby instruct the insurance carrier to pay you directly any monies due you for medical services you rendered to me. **I authorize you and or your attorney to receive from my insurer, immediately upon verbal request, all information regarding last payment made by said insurer on my claim, including date of payment and balance of benefits remaining.**

I authorize you and or your attorney to obtain medical information regarding my physical condition from any other health care provider, including hospitals, diagnostic centers, etc., and I specifically authorize such health care provider(s) to release all such information to you about me, including medical reports, X-ray reports, narrative reports, and any other report or information regarding my physical condition.

Dated: 2/27/19

Patient's Signature

Patient's Name (Print)

EXHIBIT C

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

SSRGA LAW
270 MADISON AVE

NEW YORK NY 10016

CARRIER

PICA

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare#) / (Medicaid#) / (ID#/DoD#) / (Member ID#) / X (ID#) / ( ) (ID#) / ( ) (ID#)	1378715902
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): T[redacted] OTTO[redacted]	3. PATIENT'S BIRTH DATE MM DD YY: [redacted] SEX: M X F
5. PATIENT'S ADDRESS (No., Street): [redacted]	6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other
CITY: [redacted] STATE: NJ	8. RESERVED FOR NUCC USE
ZIP CODE: [redacted] TELEPHONE (Include Area Code): ([redacted]	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): TU[redacted] OTTO[redacted]	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER: 1378715902 / GT5977	a. EMPLOYMENT? (Current or Previous): YES / X NO
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES / X NO PLACE (State)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES / X NO
d. INSURANCE PLAN NAME OR PROGRAM NAME: OXFORD HEALTH PLA	10d. CLAIM CODES (Designated by NUCC)

4. INSURED'S NAME (Last Name, First Name, Middle Initial): T[redacted] OTTO[redacted]
7. INSURED'S ADDRESS (No., Street): [redacted]
CITY: [redacted] STATE: NJ
ZIP CODE: [redacted] TELEPHONE (Include Area Code): (201) 4240004
11. INSURED'S POLICY GROUP OR FECA NUMBER
a. INSURED'S DATE OF BIRTH MM DD YY: [redacted] SEX: M X F
b. OTHER CLAIM ID (Designated by NUCC)
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? X YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on file DATE 02|22|2019

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED Signature on file

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES NO $ CHARGES 0 00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. S62636B B. S66396A C. S6981XA D. S67197A
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 02 19 2019	02 19 2019	23		13132		A	20595 00	1		NPI	1174695001
2 02 19 2019	02 19 2019	23		26765	59 F9	B	7195 00	1		NPI	1174695001
3 02 19 2019	02 19 2019	23		11010		B	1600 00	1		NPI	1174695001
4 02 19 2019	02 19 2019	23		99284	25	C D	1985 00	1		NPI	1174695001
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
221998045 X	259527949	X YES NO	$ 31375 00	$ 8916 00	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (201) 7964100
FISCHER, ROBERT S	ST. JOSEPH WAYNE HOSPITAL 224 HAMBURG TPK WAYNE NJ 070471234	FISCHER, ROBERT S 19 21 FAIR LAWN AVE FAIR LAWN NJ 074102331
SIGNED 09|11|2019 DATE	a. 1598760829 b.	a. 1174695001 b.

PATIENT AND INSURED INFORMATION

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-1197 FORM 1500 (02-12)

EXHIBIT D

Oxford Health Plans NY Inc
UnitedHealthcare - Oxford
4 Research Drive
Shelton CT 06484
Phone: 1-800-666-1353

STD - PRA

UnitedHealthcare Oxford

PROVIDER REMITTANCE ADVICE

CHECK DATE: 05/29/19
TIN: 221998045
VENDOR NAME: ROBERT S FISCHER
CHECK NUMBER: 15994983
CHECK AMOUNT: $8,466.00
VENDOR ID: P1998045-P1998045

ROBERT S FISCHER
1821 FAIR LAWN AVE
FAIR LAWN NJ 07410

PATIENT: OTTO [redacted]

MEMBER ID: [redacted] PATIENT ACCT NUM: 35884761 CLAIM NUMBER: [redacted]
PROVIDER ID: P1998045 PROVIDER NAME: FISCHER, ROBERT

DATE(S) OF SERVICE	DESCRIPTION OF SERVICE	QTY	BILLED AMT	MAXIMUM AMOUNT	DEDUCTIBLE AMT	COPAY/COINS AMT	COB AMT	WITHHOLD AMT	PAYMENT AMT	PATIENT RESP AMT	ADJ CODE
02/19/19	REPAIR OF WOUND OR LESION (13132)	1	$0.00				$0.00	$0.00	$0.00	$0.00	T317
02/19/19	TREAT FINGER FRACTURE, EACH (26746-59)	1	$7,195.00	$6,240.00			$0.00	$0.00	$6,240.00	$0.00	A31P
02/19/19	DEBRIDE SKIN ATTX SITE (11010)	1	$0.00				$0.00	$0.00	$0.00	$0.00	D11E
02/19/19	ER DEPART VISIT HIGH SEVERITY (99284-25)	1	$1,905.00	$1,096.00			$0.00	$0.00	$1,096.00	$0.00	A79
02/19/19	REPAIR OF WOUND OR LESION (13152-51)	1	$20,505.00				$0.00	$0.00	$0.00	$0.00	D11
02/19/19	DEBRIDE SKIN ATTX SITE (11010)	1	$1,600.00	$1,200.00			$0.00	$0.00	$1,200.00	$0.00	A31R
CLAIM 0884P65441 01 PSYCHOTAL			$31,875.00	$8,466.00			$0.00	$0.00	$8,466.00	$0.00	
								TOTAL PAYABLE TO PROVIDER	$8,466.00		

Adjustment Code Description

A31P The maximum amount allowed for this primary procedure has not been reduced based on the multiple procedures policy.

A31R We have applied the maximum amount allowed for this service. The amount allowed for this service has been reduced based on the multiple procedures policy.

A79 This claim has been paid at 100% of the usual, customary and reasonable allowance for the services provided. Please do not bill the patient above the amount of any co-insurance, co-pay or deductible that is applied to this service. If you have any questions concerning the processing of this claim, contact Provider Services at 800-666-1353.

D11 This service is not eligible for reimbursement as a separate procedure as it is considered part of the more global procedure that was performed and is therefore considered inclusive.

D11E This code has been replaced.

T317 This adjustment code has been applied to indicate that multiple surgical procedures were performed during the same operating session. This claim has been reimbursed in accordance with Oxford's Multiple Surgery policy, which is based upon generally accepted insurance industry standards for reimbursement of multiple surgical procedures. Under this policy, the primary procedure is reimbursed at 100% of the fee schedule (minus any applicable member cost-share). All subsequent procedures are reimbursed at 50% of the fee schedule. The primary surgery has been determined using the Medicare methodology of relying on the Relative Value Units (RVU). Participating providers may not balance bill the member for this service.

For the above claims please visit www.oxhp.com

EXHIBIT E

Freedom Health Associates

"More than a medical billing company, a Partnership"
www.freedomhealthassociates.com

1 South Main St.
Suite 5
Lodi, NJ 07644
Phone 800-260-2125
Fax 973-246-9561

June 10, 2019

UnitedHealthcare/Oxford
Appeals Resolution Team
PO Box 29136
Hot Springs, AR 71903

Re: T[redacted] Otto
CLAIM # **9054E05441.01**
ID# **13787159*02**
DOS: 02/19/2019

To Whom It May Concern:

I am writing on behalf of Robert S. Fischer, M.D. to address claim adjudication error(s) involving the payment received for services provided by Dr. Fischer to the above-mentioned patient. You have incorrectly applied a discount to the claim when there is no contract between our practice and the plan. Also you have incorrectly denied CPT code 13132 for multiple surgical procedure. 13132 was separate procedure.

I am attaching proof of higher payment received for the same type of service(s) to support our request for additional payment and to assist you in stablishing a better UCR rate for the services(s) rendered by the provider.

Since Dr. Fischer is an "out-of-network" provider, he is entitled to payment at his fee-for-service billed rate. We request that you send a corrected EOB to the practice and to the patient along with the additional payment due.

Sincerely,

Agata J Sieron
Freedom Health Associates, LLC
Medical Collections Representative
Cc: Callagy Law, P.C.

EXHIBIT F

Oxford Health Plans NY Inc
UnitedHealthcare - Oxford
4 Research Drive
Shelton CT 06484
Phone: 1-800-888-1353

STD PRA

UnitedHealthcare Oxford

PROVIDER REMITTANCE ADVICE

CHECK DATE: 07/03/19
TIN: 221986045
VENDOR NAME: ROBERT S FISCHER
CHECK NUMBER: 17978569
CHECK AMOUNT: $450.00
VENDOR ID: P1986045-P1986045

ROBERT S FISCHER
1991 FAIR LAWN AVE
FAIR LAWN NJ 07410

PATIENT: OTTO T[redacted]

MEMBER ID: [redacted] PATIENT ACCT NUM: [redacted] CLAIM NUMBER: [redacted]
PROVIDER ID: [redacted] PROVIDER NAME: [redacted]

DATE(S) OF SERVICE	DESCRIPTION OF SERVICE	QTY	BILLED AMT	MAXIMUM AMOUNT	DEDUCTIBLE AMT	COPAY/COINS AMT	COB AMT	WITHHOLD AMT	PAYMENT AMT	PATIENT RESP AMT	ADJ CODE
02/19/19	REPAIR OF WOUND OR LESION (13132)	1	$0.00				$0.00	$0.00	$0.00	$0.00	T317
02/19/19	TREATINGER FRACTURE EACH (26765-59)	1	$7,185.00	$2,340.00			$0.00	$0.00	$2,340.00	$0.00	A31P
02/19/19	DEBRIDE SKIN AT FX SITE (11010)	1	$0.00				$0.00	$0.00	$0.00	$0.00	D11E
02/19/19	ER DEPART MOD HIGH/SEVERE SEVER (99284-25)	1	$1,085.00	$1,028.00			$0.00	$0.00	$1,028.00	$57.00	A79
02/19/19	REPAIR OF WOUND OR LESION (13132-51)	1	$29,588.00	$450.00			$0.00	$0.00	$450.00	$0.00	A31R
02/19/19	DEBRIDE SKIN AT FX SITE (11010)	1	$1,500.00	$1,200.00			$0.00	$0.00	$1,200.00	$0.00	A31P
	Less amount previously paid		$31,375.00	-$8,486.00			$0.00	$0.00	$8,468.00	$57.00	
	CLAIM 9B84E0644F 02 SUBTOTAL		$0.00	$450.00			$0.00	$0.00	$450.00	$57.00	
								TOTAL PAYABLE TO PROVIDER		$450.00	

Adjustment Code Description

A31P The maximum amount allowed for this primary procedure has not been reduced based on the multiple procedures policy.

A31R We have applied the maximum amount allowed for this service. The amount allowed for this service has been reduced based on the multiple procedures policy.

A79 This claim has been paid at 100% of the usual, customary and reasonable allowance for the services provided. Please do not bill the patient above the amount of any co-insurance, co-pay or deductible that is applied to this service. If you have any questions concerning the processing of this claim, contact Provider Services at 800-666-1353.

D11E This code has been replaced.

T317 This adjustment code has been applied to indicate that multiple surgical procedures were performed during the same operating session. This claim has been reimbursed in accordance with Oxford's Multiple Surgery policy, which is based upon generally accepted insurance industry standards for reimbursement of multiple surgical procedures. Under this policy, the primary procedure is reimbursed at 100% of the fee schedule (minus any applicable member cost-share). All subsequent procedures are reimbursed at 50% of the fee schedule. The primary surgery has been determined using the Medicare methodology of relying on the Relative Value Units (RVU). Participating providers may not balance bill the member for this service.

For the above claims please visit www.oxhp.com

ENTERED

Oxford Health Plans NY Inc
UnitedHealthcare - Oxford
4 Research Drive
Shelton CT 06484

UnitedHealthcare
Oxford

JPMorgan Chase Bank, N.A.
Syracuse, NY 13260

93-939
313

17070569

DATE: 07/09/19

REF ID: 2294-09

(not valid after 180 days)

PAY $*********450.00**

Four Hundred Fifty Dollars and Zero Cents

PAY TO THE ORDER OF
ROBERT S REICHER
1921 FAIR LAWN AVE
FAIR LAWN NJ 07410

AUTHORIZED SIGNATURE

⑈017070569⑈ ⑆021309379⑆ 60187229⑉

EXHIBIT G

Freedom Health Associates

"More than a medical billing company, a Partnership"
www.freedomhealthassociates.com

1 South Main St.
Suite 5
Lodi, NJ 07644
Phone 800-260-2125
Fax 973-246-9561

August 22, 2019

Oxford Health Insurance
Appeals Request Department
PO Box 29139
Hot Springs, AR 71903

Re: **T[redacted], Otto**
CLAIM # **9054E05441.02**
ID# **1378715902**
DOS: **2/19/19**

To Whom It May Concern:

I am writing on behalf of Robert S. Fischer, M.D. to address claim adjudication error(s) involving the payment received for services provided by Dr. Fischer to the above-mentioned patient. You have substantially underpaid the claim when there is no contract between our practice and the plan. You also originally denied CPT code 13132 for a multiple procedure. 13132 was a separate procedure.

The claim was appealed on the member's behalf and $450.00 was allowed and paid for 13132. This amount is unsatisfactory. We are submitting a **2nd Level Provider Appeal.**

We are seeking additional payment on the three CPT codes 13132, 26765 and 11010.

In a letter we received from UHC/Oxford dated August 8, 2019 it states UnitedHealthCare uses the FH Benchmarks in determining reasonable and customary charges. Also that this plan uses the 75th percentile. I have attached the charges established as reasonable and customary charges by Fair Health in the 75th percentile for our geographic area. We are seeking additional payment on the three CPT codes on the Fair Health list that is attached.

You will see for CPT code 13132 there was a payment of $450.00 Fair Health has it at $1250.00. For CPT code 26765 there was a payment of $6420.00 Fair Health has it at more than what was billed and UnitedHealthCare still under paid it. For CPT code 11010 there was a payment of $1200.00 once again underpaid according to Fair Health Benchmarks.

Freedom Health Associates

"More than a medical billing company, a Partnership"
www.freedomhealthassociates.com

1 South Main St.
Suite 5
Lodi, NJ 07644
Phone 800-260-2125
Fax 973-246-9561

Please be advised the service(s) rendered were "EMERGENCY SERVICES" and that the substantial discount that is being applied to the total charges is **UNACCEPTABLE**.

I am attaching proof of higher payment received for the same type of service(s) to support our request for additional payment and to assist you in establishing a better UCR rate for the service(s) rendered by the provider.

Since Dr. Fischer is an "out-of-network" provider, he is entitled to payment at his fee-for-service billed rate. We request that you send a corrected EOB to the practice and to the patient along with the additional payment due

Sincerely,

Greg Jensen
Freedom Health Associates, LLC
Medical Collections Representative